Illinois State Board of Education
New U.S. Department of Education Race and Ethnicity Data Standards
DOLTON SCHOOL DISTRICT 149
2024-2025

Student's Name: ____________________________________ (pre-printed by school district)

SIS ID: __________________________ (pre-printed by school district)

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one**.

☐ **No, not Hispanic/Latino**

☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to that question below marking one or more boxes to indicate what you consider this student this student's race to be.

Part B. What is the student's race? Choose one or more.

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

☐ **Asian (**A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black of African American** (A person having origins in any of the black racial groups of Africa.)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North America.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

Parent Signature Line: ____________________________________

Dolton School District 149
New Student Registration Form
2024-2025

A person who knowingly or willfully provides false information to a school district regarding the residency of a pupil for the purpose of enabling the pupil to attend any school in the district without the payment of a nonresident tuition charge commits a Class C misdemeanor (not more than thirty days in jail and/or a fine not to exceed $1500.00). School Code 105ILCS 5/20.1b & 730ILCS 5/5-9-1

Student Last Name: ____________________________ Student First Name: _______________________

Student Middle Name: _________________________ Birthdate____/_____/_________

Ethnic Origin: __________________________ Gender: F M Last Grade Attended_____

Home Phone #: ________________________ Cell/Pager #: _________________________

Office Use Only:
Residency
Verified By:
____

Homeless? Yes_____ No ______ if yes, complete the residency verification forms and contact our Homeless Liaison to set up an appointment at 708-868-8300.

Family Street Address: ___________________________________City: _________________ IL 604 _____

Parent/Guardian/Foster Name: ____
(Circle one) Last Name First Name

Address if different from above: ____

Employer: ____ Work Phone #__________________________

Parent/Guardian/Foster Name: ____
(Circle one) Last Name First Name

Address if different from above: ____

Employer: ____ Work Phone #__________________________

Primary Language Spoken at Home: ____

Pertinent Medical

Information:____

____

____

____

Emergency Contact: ____Relationship: ___________________

Phone #: ____

Please check one of the statements below in reference to member of branch of the Armed Forces of the United States.

___ I am a parent or guardian who is a member of a branch of the armed forces of the United States and who is deployed to active duty.

___ I am not a parent or guardian who is a member of a branch of the armed forces of the United States.

SCHOOL INFORMATION

Previous School (s) Attended

Grade/Year	School	Address	District	City	State	Last Attended
/						
/						
/						
/						

Siblings attending District 149:

Name ____ School _______________________________________

Name ____ School _______________________________________

Name ____ School _______________________________________

Was your child receiving any special services beyond the regular classroom?

Learning Disabilities _____Yes ____No   Counseling or Social Work ____Yes ____No

Accelerated or Gifted ____Yes ____No   Speech or Language Therapy ____Yes ____No

Behavior Disordered _____Yes ____ No   Band Instrument ____Yes ____No

Has your child ever been retained? ______Yes _____No   If yes, at what grade level _____________

Was behavior a problem for your child in his previous school (s)? _____Yes ______No

If yes, please explain using specific examples:

____
____
____
____

Office Use Only

Has a transfer from previous school: ________ Yes _______No

Has a current IEP: _____Yes ______No Busing Transportation: _______Yes ________No

Student: ____

Assigned to Homeroom#: ____________________ Teacher: _____________________________

7/28/2022

DOLTON SCHOOL DISTRICT 149

RESIDENCY ATTESTATION FORM
2024-2025

To be used when a lease is not available:

In order to comply with Dolton School District 149 proof of residency requirement, I verify the following information for

Name of Student(s) and Custodian(s)

____

____

____

I, ____________________________________ am the _____ owner _____ lease holder _____ landlord residence
(place an X in the appropriate space)

located at ____
Number, Street, Apt# City State Zip Code

I attest that the student(s) named above and his/her custodian(s) have been living at the above address since _______________(date).

Owner/Leaseholder/Landlord ____ ________________
Signature Date

Home Address ____ Phone _______________________

Property owners must attach a copy of their current real estate document.

Leaseholders must attach a copy of the current lease.

Landlords may be asked to provide additional information at a later time.

***Attestation of Residency

School District 149

292 Torrence Avenue
Calumet City, Illinois 60409
708-868-8300
708-868-7850
www.sd149.org

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HEALTH HISTORY
2024-2025

Name: ____________________________________ Gender: _______ Date: ________
Last First M.I.
Address: ____ Phone # ______________

Place of Birth: ______________________________ Date of Birth: ________________

Does child have any major physical disability? __________ Yes __________ No
If yes, please explain:
____

Is your child allergic to peanuts/peanut oil? _____________ Yes __________ No
If yes, please explain:
____

Does your child wear glasses? ________ Yes ___________ No

Is your child taking any medications? _________ Yes _________ No
If yes, please explain:
____

Disease History	YES	NO	Disease History	YES	NO
Allergy	____	____	Scarlet Fever	____	____
Asthma	____	____	Streptococcus Infection	____	____
Bronchitis	____	____	Heart Disease	____	____
Otitis (ear infection)	____	____	Rheumatic Fever	____	____
Chicken Pox	____	____	Pneumonia	____	____
German Measles	____	____	Diabetes	____	____
Measles	____	____	Epilepsy	____	____
Mumps	____	____	Convulsions (seizures)	____	____

Name(s) of siblings attending school:

Names	School	Grade
____________________________________	______________	_______
____________________________________	______________	_______
____________________________________	______________	_______

In case of emergency in where the parent/guardian cannot be reached, the following should be contacted:
Name: _____________________________________ Phone#_________________
Name: _____________________________________ Phone # _________________

07/2022

School District 149

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Age of Vaccination	DTP	TD	OPV or IVP	MMR	HIB	Hep B	Varicella	Tdap	Meningococcal MCV
1-2 months						X			
2 months	X		X		X				
4 months	X		X		X	X			
6 months	X		X		X				
6-18 months						X			
12-15 months				X	X		X		
15 months	X								
2-3 years*					X				
4-6 years**	X		X	X		Series	X		
10-11 years***						Series		X	X
Every 10 years		X							

*Preschool students must have completed the immunizations on this line and above.

**This series of boosters is required before starting school.

***All students entering 6th grade must have completed series of Hepatitis B and other required series before starting school.

If you need assistance concerning this information, please contact the Cook Country Department of Public Health, your physician, or your school nurse.

DOLTON SCHOOL DISTRICT 149

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August 2024

Dear Parents/Guardians:

The following are requirements for physical examinations, immunizations, dental examinations and vision examinations for the **2024-2025** school year. All forms are located in the School Health Office and on our district website at www.sd149.org.

- **Physical Examinations/Immunizations are due October 15, 2024.** All children are required by Illinois law to have a **physical examination and required immunization** by a licensed physician prior to entrance into **pre-kindergarten, kindergarten, and 6th grade.**
- **A Diabetes screening is mandatory** as a part of the physical health examination.
- In conjunction with the health physical, a **mandatory Lead screening** is required for children aged **1-7 years old.**
- **Dental Examinations are due May 15, 2025**. A **dental examination** is mandatory for entry into **kindergarten, 2nd, and 6th grades.**
- **Vision Examination**-Public Act 95-671, effective January 1, 2008, requires that all children enrolling in kindergarten in a public, private or parochial school and any student enrolling for the first time in a public, private or parochial school shall have an eye examination. Each child is to present proof of having been examined by a licensed physician or a licensed optometrist within the previous year before October 15 of the school year.
- **Tdap-**A new rule was enacted in August 2011 to increase the proportion of students in grades **6th-12th** who are vaccinated against pertussis. The new rule stipulates that children entering grades **6th-12th** must show proof of receiving one dose of Tdap regardless of the interval since the last DTaP, DT or Td dose.
- **MCV –** A new rule was enacted in August 2015. All students entering **6th** grade must show proof of receiving one dose of MCV.

During School year 2023-2024 students entering 6th, 7th, or 8th grade will be required to provide documentation of receipt of one dose of Tdap.

The chart explains all the **required immunizations needed before entry into pre-kindergarten, kindergarten and 6th grade for the 2023-2024 school year**.

DTP (*diphtheria, tetanus & pertussis)*/**TD** (*tetanus & diphtheria)*/**OPV** or **IVP** (*polio vaccine)*/**MMR** (*measles, mumps & rubella*)/**HIB** *(type of meningitis*)/**Hep B** (*hepatitis B vaccine/**Tdap** (tetanus, diphtheria, & pertussis) **MCV** (Meningococcal)*

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Home Language Survey
2024-2025

The State of Illinois requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps identify students that need to be assessed for English language proficiency. Please answer the questions below and return this survey to your child's school.

Student's Name____

School____

Age ______ Grade ______ Date of birth ________________________

1. Is there a language other than English spoken in daily interaction in your home? Yes _____ No _____

   If yes, what language? ________________________________

2. Does your child speak a language other than English in your daily interaction in your home? (**This does not include language learned in a classroom setting.)** Yes ______ No ______

   If yes, what language? __________________________________

   If the answer to either question is yes, Illinois law requires the district to assess your child's English language proficiency.

3. Will you require an interpreter for school related information?
   Yes ______ No ______

______________________________   _______________________

Parent/Guardian Signature   Date

Screener Date: _________________   Enrollment Date: ______________

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Encuesta del Idioma del Hogar
2024-2025

El Estado de Illinois requiere que el distrito obtenga una encuesta del idioma del hogar para cada nuevo estudiante. Esta información se utiliza para contar los estudiantes cuyas familias hablan un idioma diferente al inglés en casa. También ayuda a identificar a los estudiantes que necesitan ser evaluados para la habilidad del dominio del inglés. Por favor, conteste las preguntas abajo y retorne esta encuesta a la escuela de su hijo.

Nombre del estudiante ____

Escuela____

Edad ________ Grado______ Fecha de nacimiento ________________

1. ¿Existe un idioma distinto del inglés hablado en la interacción diaria en su casa?
   Sí ______ No ______

En caso afirmativo, ¿en qué idioma? ______________________________

2. ¿Su hijo habla un idioma diferente al inglés en su diario interacción en tu casa? **(Esto no incluye idioma aprendido en un entorno de aula).**
   Sí ______ No ______

En caso afirmativo, ¿en qué idioma? _____________________________

Si la respuesta a cualquier pregunta es afirmativa, la ley de Illinois requiere que el distrito evaluar el dominio del idioma Inglés de su hijo.

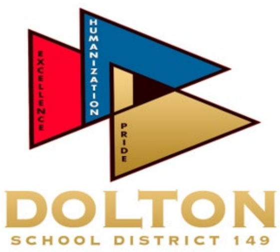
3. ¿Desea un intérprete para la información relacionada de la escuela?
   Sí ______ No ______

_______________________________________ ______________

Firma del Padre/Madre/Encargado/Tutor Legal Fecha

________________________________ ______________

Para uso de officinal solamente Fecha de inscripción



DOLTON SCHOOL DISTRICT 149

PARENT IN GOOD STANDING FORM
2024-2025

I, ____________________________________ agree that my child is in "good standing"
Parent/Guardian Name

(with academics, medical compliance and discipline). I further agree that my child(ren) was/were not expelled during the period in which I am enrolling. I understand that if this information is found to be falsified, my child(ren) will be transferred out of School District 149.

This form in only good for one (1) school year, private/parochial school transfer document.

Child's Name ____

District 149 School ____ Grade ________

Parent/Guardian Signature ____

Home Address ____

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CONSENT FOR RELEASE OF SCHOOL STUDENT RECORDS
2024-2025

I hereby consent to the release of the following information from the school student records of:

Student Name: ____

□ Education information from the: □ Permanent Record □ Temporary Record

□ Psychological, Social and Medical Information

□ Other:

____

____

Please release the above information to the following school/person:

School Name: ____

Address:____

Telephone/Fax:____

The reason for release:____

I understand that I have the right to inspect, copy, and challenge the contents of the school student records in question prior to release and the right to limit any consent for the release of the school student records designated records or designated portions of information in the school student records.

Name: ____ Date: __________________

Signature of Parent/Guardian

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August 2024

Dear Parent/Guardian**:**

The School Code of Illinois, Chapter 105, Article 5/27-8.1 states that all children are required to have a physical examination and all required immunizations prior to kindergarten and 6th grade and irrespective of grade, immediately prior to entrance into school if the child has not been previously examined. **For entry into kindergarten, 2nd and 6th grade a Dental Examination is <u>mandatory.</u>** Failure to provide the required medical records will result in your child and/or children being withdrawn from our district for the 2024-2025 school and a transfer will be issued.

_____Record of physical examination

_____Complete record of immunizations that comply with Illinois requirements

_____**All 6th graders need a New Physical Examination, Tdap, and Meningococcal Conjugate (MCV4)**

_____DTaP or Tdap

_____Polio (OPV/IPV) booster

_____MMR: 1st MMR, 2nd MMR (measles, mumps, rubella)

_____Hepatitis B series (1st, 2nd, 3rd)

_____Written schedule for completion of required immunizations

_____Varicella Vaccine: 1st Varicella, 2nd Varicella or proof of the chicken pox disease

_____Dental Exam

_____Kindergarten eye examination or eye examination waiver form

It is our goal to have all of our students return to Dolton School District 149. If you are in need of assistance, please feel free to contact your building principal or school nurse.

Thank you,

Dr. Maureen M. White
Superintendent of School

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New Student Registration Requirements 2024-2025

A person who knowingly or willfully provides false information to a school district regarding the residency of a pupil for the purpose of enabling the pupil to attend any school in the district without payment of a nonresident tuition charge commits a Class C misdemeanor (not more than thirty days in jail and/or fine not to exceed $1500.00)
SCHOOL CODE: 105KLCS 5/20.12B & 730 ILCS 5/5-9-1.

Below is a list of acceptable proofs of residency that are required to register a new student in Dolton School District 149. **All documents must have an address within the Dolton School District 149 attendance boundaries.**

Mandatory Documents:
- Original certified birth certificate
- Valid state issued I.D. or driver's license *
- Official transfer from the child's previous school
- Current/updated physical including immunization records

Category A: One (1) document from this list:
- Real Estate tax bill
- Signed lease
- Mortgage document or payment book
- Residency Attestation
- Military housing letter
- Section 8 letter

Category B: Two (2) documents from this list:
- Utility bill (i.e.: gas bill, electric bill, water bill)
- Phone bill (no cellular phone bills)
- Cable bill
- Vehicle registration
- Bank statement
- Public Aid card/Medicaid card
- Credit card statement
- Paycheck stub
- City sticker receipt

***Dolton School District 149 fully complies with all registrations for undocumented immigrants in compliance with Plyer v. Doe to ensure equal educational access for all!**

DOLTON SCHOOL DISTRICT 149

NEW STUDENT REGISTRATION – REQUIRED DOCUMENT LIST
2024-2025 SCHOOL YEAR

Student Name ___________________________________ Grade _________ School Year __________

Parent/Guardian Name __________________________________ Contact Number ________________

Address ____

Mandatory Documents:

☐ Original certified birth certificate

☐ Valid state issued I.D. or driver's license *

☐ Official transfer from the child's previous school

☐ Current/updated physical including immunization records

Category A: One (1) document from this list:

☐ Real Estate tax bill

☐ Signed lease

☐ Mortgage document or payment book

☐ Residency Attestation

☐ Military housing letter

☐ Section 8 letter

Category B: Two (2) documents from this list:

☐ Utility bill (i.e.: gas bill, electric bill, water bill)

☐ Phone bill (no cellular phone bills)

☐ Cable bill

☐ Vehicle registration

☐ Bank statement

☐ Public Aid card/Medicaid card

☐ Credit card statement

☐ Paycheck stub

☐ City sticker receipt

Indiana/Illinois

CONSENT FOR DENTAL SERVICE

Your school and The Heart That Smiles Mobile Dentist has arranged for dental services for eligible children. These services may include dental screening/exam, cleaning, fluoride treatment, and sealants *(if qualified).* Licensed Dentists, Certified Dental Assistants and/or a Public Health/Access Practice Dental Hygienist will come to your child's school with portable equipment. **If you would like your child to participate, please complete the below information and return it to your child's school. This signed consent includes an initial visit and 6-month follow-up IF scheduled.**

School Name: ______________________ Classroom # __________ Grade: ________

Student Name: ______________________ **Date of Birth:** ___/___/_____ Gender: ____

Home Address: ______________________ Apartment # __________

City: ______________________ Zip Code: __________ Phone Number: (____) __________

Has your child had any history of, or conditions related to, or any of the following:

___ Anemia ___ Chronic Sinusitis ___ Growth Problem ___ Seizures ___ Asthma ___ Diabetes ___ Hearing ___ Fainting
___ Bleeding disorders ___ Thyroid disease ___ Heart disease ___ Tobacco/Drug use ___ Cancer ___ Epilepsy
___ Latex Allergy ___ Cerebral Palsy ___ Pregnancy (teen) ___ STD/AIDS

Other or Allergies: ______________________

Is your child taking any prescription and/or over-the-counter medications at this time? Yes / No

If yes, please list: ______________________

Does your child have any speech difficulties? Yes / No Any Learning Disabilities? Yes / No

Has your child suffered injuries to the mouth, head, or teeth? Yes / No If yes: ______________________

Any dental concerns with your child's teeth? ______________________

Medicaid Illinois or Medicaid Indiana: If your child is covered by either, please included ID number:

__ __ __ __ __ __ __ __ __

Name of private dental insurance: ______________________

Insurance phone number: ______________ Group Number: ______________

Private Ins Company Policy #:______________Name of Parent/Guardian Insured:______________

Date of Birth of Insured: ___/___/_____ Social Security Number of Insured Person______________

- I have no dental insurance and I would like to someone to contact me about how I can still receive these great services. 708-808-4950

PRINT NAME: ______________________ **Relationship:** Parent / Guardian

SIGNATURE: ______________________ **DATE:** ______________

By signing this form, you give permission to treat your child. This will also give permission for IDPH quality assurance exams. I understand that all dental screenings or exams are completed either by a Licensed Dentist OR by a Public Health/Access Practice Dental Hygienist and the services redeemed may reduce future dental insurance benefits. Dental screenings are not comprehensive exams. Failure to follow up with your dentist, may result in increased dental disease for which the patient is responsible. Our privacy policy is available on our website. Copies available upon request. A report card will go home with your child following the dental visit. If you do not receive a form, please call us at number listed below.

Indiana:1112 U.S. Highway 41, Schererville, IN. 46375
Illinois: 430 Dixie Hwy #101, Chicago Heights, IL. 60411
Phone: 708-808-4950 Fax: 708-794-0466 E-Mail: info@heartsmiles.org
www.heartsmiles.org

INDIANA
ILLINOIS

CONSENTIMIENTO PARA SERVICIO DENTAL

Su escuela y The Heart That Smiles Mobile Dentist han hecho arreglos para servicios dentales para niños elegibles. Estos servicios pueden incluir exámenes/evaluaciones dentales, limpieza, tratamiento con fluoruro y selladores (si califica). Dentistas con licencia, asistentes dentales certificados y/o higienistas dentales de salud pública acudirán a la escuela de su hijo con equipos portátiles. **Si desea que su hijo participe, complete la siguiente información y devuélvala a la escuela de su hijo. Este consentimiento firmado incluye una visita inicial y un seguimiento de 6 meses si está programado.**

Nombre de la escuela: ___________________________________ Salón # _____________ Grado: ________

Nombre del estudiante: ____ **Fecha de nacimiento**: ___/___/_____ Sexo: ____

Dirección de casa: ____Apartamento # _________

Ciudad: __________________________ Código postal: ______________ Número de teléfono: (____) _____________

¿Ha tenido su hijo(a) algún historial de, o condiciones relacionadas con, o cualquiera de los siguientes:
___ Anemia ___ Sinusitis crónica ___ Problemas de crecimiento ___ Convulsiones ___ Asma ___ Diabetes ___ Audición ___ Desmayos ___ Trastornos hemorrágicos ___ Enfermedad de la tiroides ___ Enfermedad del corazón ___ Consumo de tabaco/drogas ___ Cáncer ___ Epilepsia___ Alergia al látex ___ Parálisis cerebral ___ Embarazo (adolescente) ___ ETS/SIDA
Otras o Alergias: ____¿Está tomando su hijo algún medicamento recetado o de venta libre en este momento? Sí No
En caso afirmativo, indique____
¿Tiene su hijo alguna dificultad en el habla? Sí / No ¿Algún problema de aprendizaje? Sí No
¿Su hijo ha sufrido lesiones en la boca, la cabeza o los dientes? Sí / No En caso afirmativo: ____________________________
¿Alguna preocupación dental con los dientes de su hijo?____

Medicaid/Illinois ALL KIDS: Si su hijo está cubierto por ALL KIDS, incluya el número de identificación:

__ __ __ __ __ __ __ __ __

Nombre del seguro dental privado: ____
Número de teléfono del seguro: _____________________________ Número de grupo: _____________________________________
Nombre del empleado: ____
Nombre del Asegurado: ____ Fecha de Nacimiento del Asegurado: ___/___/_____
Número de Seguro Social de la Persona Asegurada: ____

- No tengo seguro dental y me gustaría que alguien se comunique conmigo sobre cómo puedo seguir recibiendo estos excelentes servicios.

NOMBRE EN IMPRENTA: ____ **Relación: Padre/Tutor**

FIRMA: ____**FECHA:**___________________________

Al firmar este formulario, usted da permiso para tratar a su hijo. Entiendo que todas las evaluaciones o exámenes dentales son realizados por un dentista con licencia o por un especialista en salud Pública/Acceso Práctica Higienista y los servicios canjeados pueden reducir los beneficios futuros del seguro dental. Los exámenes dentales no son exámenes completos. La falta de seguimiento con su dentista puede resultar en un aumento de la enfermedad dental de la que el paciente es responsable. Nuestra política de privacidad está disponible en nuestro sitio web. Copias disponibles a pedido. Una boleta de calificaciones se enviará a casa con su hijo después de la visita al dentista. Si no recibe un formulario, llámenos al número que se indica a continuación.

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